

FOR STATE HEALTH DEPT.

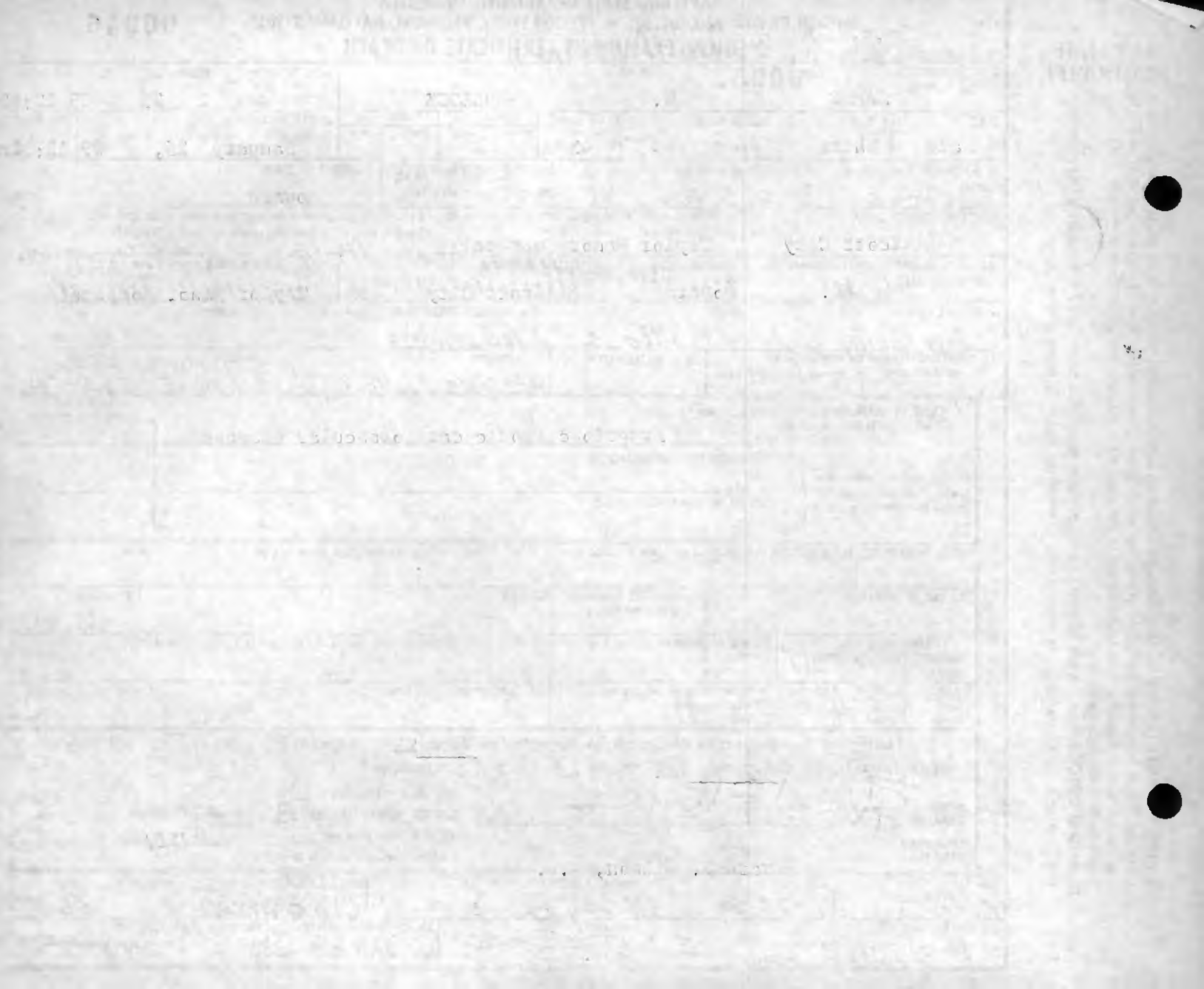
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items#13e,c, FILM#409757769
Items#13a,b,c,e, MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00946

1. DECEASED-NAME (Type or Print) JAMES W. BULLOCK		2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year 1 25 1969		2b. HOUR 12:30
3. SEX Male	4. RACE White	5. DATE OF BIRTH FEB 26 1925	6. AGE (In years last birthday) 43 YRS.	7c. DATE PRONOUNCED DEAD Month Day Year January 25, 1969
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Howard
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Taylor Manor Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Ohio Mad		13b. COUNTY Howard	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET AND NUMBER 3601 Center St. 6958 Miami BLUFF Drive
14. FATHER'S NAME First Middle Last Anthony D Bullock		15. MOTHER'S MAIDEN NAME First Middle Last Adelaide ORR		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Adelaide Bullock 6958 Miami BLUFF Dr. MARIEMONT Ohio 45227
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Edward F. Wilson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 1/25/69
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE 1-27-69	23c. NAME OF CEMETERY OR CREMATORY SPRING GROVE	23d. LOCATION (City or Town) Cincinnati (County) Ohio (State)	
24. FUNERAL DIRECTOR Higinbotham-Slack FUNERAL HOME		ADDRESS Ellicott City, Md. 21043		25a. REC'D BY REGISTRAR JAN 28 1969
		25b. REGISTRAR'S SIGNATURE Charles Judge		



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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00952

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00947

1. DECEASED-NAME (Type or Print) DAVID			First Middle Last EUGENE			Last CARLIN			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year Jan. 19, 1969			2b. HOUR 11:20			
3. SEX Male		4. RACE White		5. DATE OF BIRTH SEPT 16, 1948		6. AGE (In years last birthday) YRS. 4 MONTHS 4 DAYS 3		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Jan. Day 19 , Year 1969			2d. HOUR 11:40		
7a. BIRTHPLACE (State or foreign country) MD Baltimore				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Howard			
10. CITY OR TOWN OF DEATH Ellicott City				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 180 Montgomery Rd.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Howard				13c. CITY OR TOWN Ellicott City				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 180 Montgomery Rd.					
14. FATHER'S NAME First Middle Last Jerome Carlin				15. MOTHER'S MAIDEN NAME First Middle Last Ruth DeBerry				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. NONE			
17. INFORMANT Jerome Carlin				ADDRESS 180 Montgomery Rd Ellicott City, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis 484X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Ronald N. Kornblum				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 1/20/69			
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 1-22-69				23c. NAME OF CEMETERY OR CREMATORY Woodlawn				23d. LOCATION (City or Town) (County) (State) Woodlawn Baltimore Md.			
24. FUNERAL DIRECTOR Higinbotham-Slack				ADDRESS Ellicott City Md.				25a. REC'D BY REGISTRAR DATE 22 1969				25b. REGISTRAR'S SIGNATURE James J. Jones			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Ruth Agnes Dennis			2a. DATE OF DEATH Month January Day 3 Year 1969			2b. HOUR 9:4 M			
3. SEX female		4. RACE white		5. DATE OF BIRTH March 12 1899		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Howard Md.			
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 144 Montgomery Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 144 Montgomery Rd.	
14. FATHER'S NAME First John Middle Baer Last Baer			15. MOTHER'S MAIDEN NAME First UNKNOWN Middle Last 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 212 36 8031		17. INFORMANT Lewis H. Dennis		Address 144 Montgomery Rd., Ellicott City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, general DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis since 1966 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac fibrillation since 1966 DUE TO, OR AS A CONSEQUENCE OF Cardiac fibrillation (c) Patient died in sleep.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-4-69 , 19__, to 1-3-69 , 19__, that (I) (we) lost the deceased alive on 12-31-68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert B Taylor MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-4-69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/6/69		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION (City or Town) (County) (State) Elkridge Howard Md.			
24. FUNERAL DIRECTOR Higinbotham Slack				ADDRESS Ellicott City, Md.		25a. RECD BY REGISTRAR DATE 1-7-1969		25b. REGISTRAR'S SIGNATURE Misses Oakes	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1042, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00954 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00949		
Items#2a, FilmGL09, 10046 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) First Middle Last Anna Mac Germany						2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> Month Day Year Jan. 12 1969			2b. HOUR M			
3. SEX Female		4. RACE colored		5. DATE OF BIRTH July 21 1929		6. AGE (In years last birthday) MONTHS DAYS HOURS MIN 39 YRS.		2c. DATE PRONOUNCED DEAD Month Day Year Jan 12 1969			2d. HOUR M	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Howard				
10. CITY OR TOWN OF DEATH Jessup				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 82A Rt#1				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Howard		13c. CITY OR TOWN Jessup		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 82A Rt#1		
14. FATHER'S NAME First Middle Last Joseph Martin						15. MOTHER'S MAIDEN NAME First Middle Last Anna Mae Mitchel						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 340X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIPLE SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 yrs.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Donald E. Fisher M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 1/12/69			
EXAMINER'S NAME (Type) Donald E. Fisher M.D.						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county) Ellicott City, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-16-1969		23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park				23d. LOCATION (City or Town) (County) (State) Laurel, Prince Georges, Md.				
24. FUNERAL DIRECTOR Robert L. Snowden						ADDRESS Rockville Md.		25a. REC'D BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00955

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00950

1. PLACE OF DEATH a. COUNTY <u>Howard County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>213 Pinewick Road</u>		d. STREET ADDRESS <u>1803 E. 28th St.</u>	
3. NAME OF DECEASED (Type or print) <u>Irene Marie KNOCHE</u>		4. DATE OF DEATH <u>Jan. 7 1969</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1902.</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>69</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Ballbah</u>		14. MOTHER'S MAIDEN NAME <u>Mary Deal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-8319</u>	
17. INFORMANT <u>Dr. William L. Knoche</u>		Address <u>10334 Malcolm Circle Cockeysville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>4109</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/9/69.</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR <u>JAN 8 1969</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>		22. DATE SIGNED <u>1-7-69</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

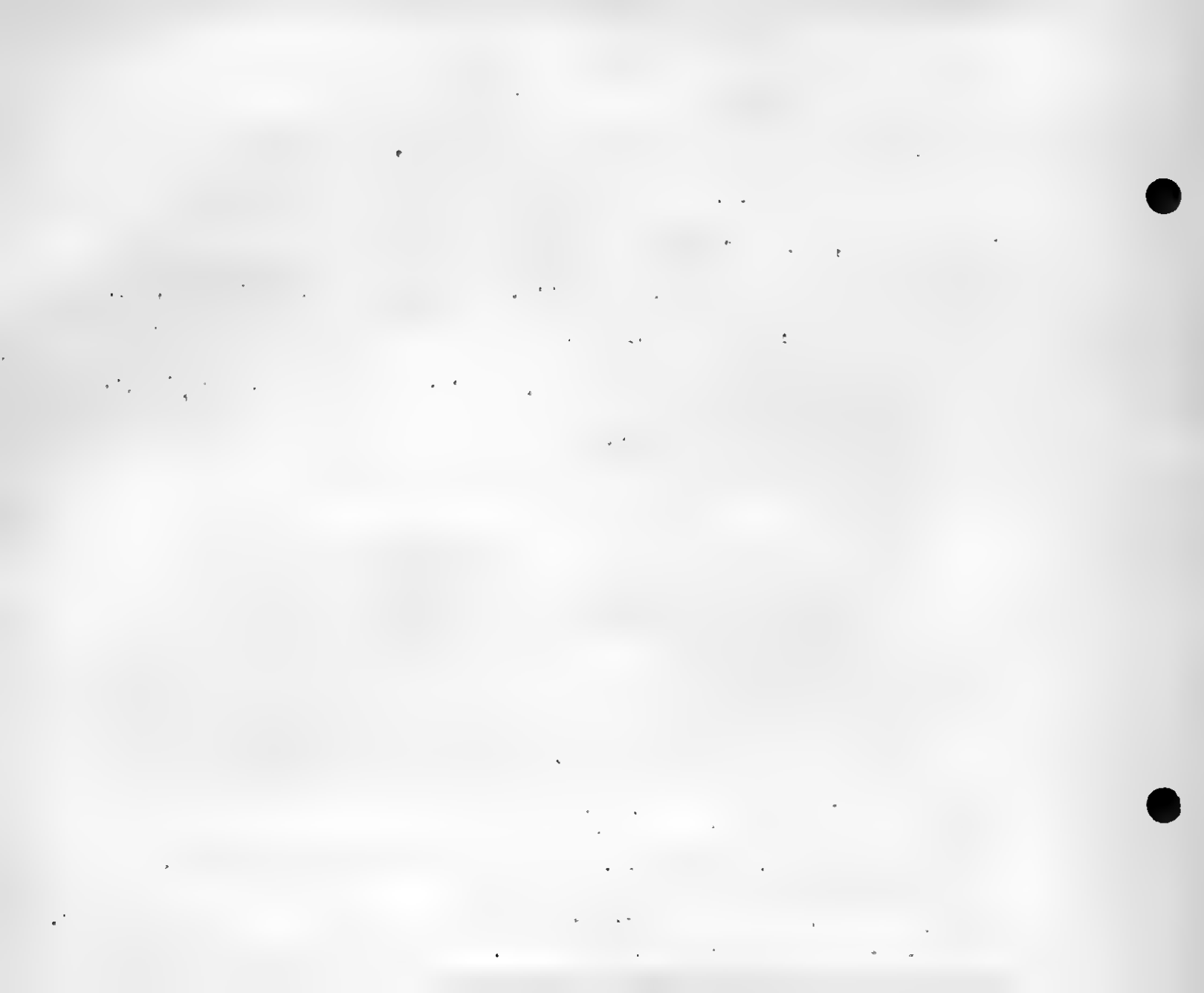
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00951, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 1 Film 09 1/29/69 kk CERTIFICATE OF DEATH 10051										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
VIOLA			PAULINE			JAN 13 1969		530 PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
FEMALE		NEGRO		6-23-1910		58 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
MD		U.S.A.				HOWARD		NONE		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of last year, even if retired)				
DAYTON			Howard Road			UNEMPLOYED				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD			HOWARD		DAYTON				HOWARD RD.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
WILLIAM			HENRY			ANNIE R. THOMAS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT Address				
NO						MRS INEZ BAILEY				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									1 MONTH	
IMMEDIATE CAUSE (a) CACHEXIA										
DUE TO, OR AS A CONSEQUENCE OF										
(b) CHR. INTESTINAL OBSTRUCTION DUE TO									1 YEAR	
DUE TO, OR AS A CONSEQUENCE OF										
(c) LARGE UTERINE FIBROID										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
COMPLETE CONGENITAL MENTAL RETARDATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 7/13, 1946, to 1/13, 1969, that (I) (we) last saw the deceased alive on 1/13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		Charles S Whitaker, M.D.		22c. DATE SIGNED		1/13/69				
22d. PHYSICIAN'S NAME (Type)		CHARLES S WHITAKER, M.D.		22e. ADDRESS		CLARKSVILLE, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		1-17-69		BROWNS CHAPEL CEM.		DAYTON HOWARD MD.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Robert L. Snowden		Rockville Md		JAN 20 1969		Charles J. Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First REBECCA			Middle H			Last NEVITT			2a. DATE OF DEATH 1 Month 7 Day 69 Year			2b. HOUR 1:45A M		
3 SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MAY 2, 1885			6 AGE (In years lost 83 day)			F UNDER 1 YEAR MONTHS DAY			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign) NORTH CAROLINA			7b. CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH HOWARD COUNTY Md.								
10. CITY OR TOWN OF DEATH ELLICOTT CITY, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) TAYLOR MANOR HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) MARYLAND N.J.			13b. COUNTY HOWARD			13c. CITY OR TOWN ELLICOTT			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 26 Howard Ave. Rd. ELLICOTT CITY, MD. 21043					
14. FATHER'S NAME First Archibald			Middle Henderson			Last Henderson			15. MOTHER'S MAIDEN NAME First Alice			Middle Johnson			Last Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT D. C. Nevitt			Address 1116 Darlene Rd. Forest Hill, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SENILITY 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from JUNE 1, 1957 , to JANUARY 7, 1969 , that (I) (we) last saw the deceased alive on JANUARY 6, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Irving J. Taylor M.D.</i>						DEGREE M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1/7/69					
22d. PHYSICIAN'S NAME (Type) IRVING J. TAYLOR, M.D.						22e. ADDRESS TAYLOR MANOR HOSPITAL, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1-9-69			23c. NAME OF CEMETERY OR CREMATORY Pohick Church Cemetery			23d. LOCATION (City or Town) (County) (State) Laton Fairfax Va.								
24. FUNERAL DIRECTOR Everly-Heatley Funeral Home						ADDRESS 1500 W. Braddock Rd., Alex.			25a. RECD BY REGISTRAR JAN 13 1969			25b. REGISTRAR'S SIGNATURE <i>James Judge</i>					



CERTIFICATE OF DEATH

00956

00953

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Ethel A. Peddicord						Jan. 23 1969			7 15 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female		White		Dec. 8, 1888			80 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Baltimore, Md.		U.S.					Howard County Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Ellicott City			Bethany Lane & Route 99								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Howard			Ellicott City			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		
Bethany Lane & Route 99			Charles			Wesley Peddicord Emily Eugenia			no		
16b. SOCIAL SECURITY NO			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1350			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
-----			Miss Florence Peddicord, Bethany La. & Rt. 99, Ellicott City, Md.			Generalized Carcinomatosis			3 M		
						(b) Ovarian Carcinoma			6 M		
						(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital), attended the deceased from 3-20, 1957, to 1-23, 1969, that (I) (we) last saw the deceased alive on 1-21, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
Peter V. Thorpe			1-24-69			S. St. Johns Lane, Ellicott City, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Jan. 25, 1969			Loudon Park Cemetery			Baltimore, Maryland		
24. FUNERAL DIRECTOR			25a. REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Harry H. Witzke, 321 Columbia Pike, Ellicott City, Md.			JAN 27 1969			Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon/paper, page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1/20/66 (095) DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00954					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN <input type="checkbox"/> Month Day Year			2b HOUR			
John			F.				Roache		DATE OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 1 14 1969			M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
male		white		11/30/1890		78 YRS						Jan 14 1969		M	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			Md			
Maryland			U.S.A.						Howard						
1d CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
Ellicott City				96 Fels Ave.				Coast Guard				retired			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY, TOWN?		13e STREET AND NUMBER					
Md.				Howard		Ellicott City		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		96 Fels Ave.					
14 FATHER'S NAME First Middle Last					15 MOTHER'S MAIDEN NAME First Middle Last										
UNKNOWN					UNKNOWN										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16b SOCIAL SECURITY NO.					17 INFORMANT ADDRESS					
yes					216 24 1622					Mrs. Mary Winkles 103 Fels Ave, Ellicott City, Md. 21042					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u>												TOUR			
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					2d AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Thomas F. Herbert</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED					
EXAMINER'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					1-14-69					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
					ADDRESS (Street, city, town, or county)										
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)							
burial			1/17/69		Good Shepherd			Ellicott City, Md.							
24 FUNERAL DIRECTOR					25a REC'D BY REG. STRIP					25b REGISTRAR'S SIGNATURE					
Higinbotham Slack					Ellicott City, Md.					JAN 22 1969					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 10-22a File 410 MARYLAND STATE DEPARTMENT OF HEALTH 3-19-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00960 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00955

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
RANDOLPH			SKIPPER			1 15 19 69			9:00
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD Month Day Year	
Male	White	Jan. 11, 1969	— YRS.	4				January 15 19 69 9:00	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md		U.S.A.				Howard			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Ellicott City			Box 8456 Horseshoe Rd.						
13a. USUAL RESIDENCE (Where deceased lived or admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
Md.			Howard			Ellicott		YES <input type="checkbox"/> NO <input type="checkbox"/>	Box 8456 Horseshoe Rd.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
UNKNOWN						VIOLET KATHLEEN PEUGH			SKIPPER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS
No			NONE			Violet Peugh			Ellicott City, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease 7469 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED
EXAMINER'S NAME (Type)			M.D.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			1/15/69
Edward F. Wilson, M.D.			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-16-69		Good Shepherd		Ellicott City		Md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. JUSTICE OF THE PEACE	
Higginbotham-Slack				Ellicott City Md.		JAN 22 1969			

628 J. S. RAL

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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<div>Item 13 Film 08</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>1/17/69 kk 0036</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>00956</div>												
1. DECEASED-NAME (Type or Print) ROBERT LEE STEVENS, Jr.						2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day Year 1-8 1969			2b. HOUR 5:35 PM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9/24/30	6. AGE (In years, last birthday) 38 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year January 8, 1969			2d. HOUR 5:35 PM			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HOWARD Md.						
10. CITY OR TOWN OF DEATH JESSUP		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PERKINS STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machine Tender			12b. KIND OF BUSINESS OR INDUSTRY Paper Board				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE M.D.		13b. COUNTY HOWARD		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER Box 230 A PERKINS STATE HOSPITAL						
14. FATHER'S NAME First Middle Last Robert Lee Stevens, Sr.				15. MOTHER'S MAIDEN NAME First Middle Last Georgette Ashburn								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 214 26 2954		17. INFORMANT Mrs. Georgette Stevens			ADDRESS Balto., Md. William St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive old myocardial infarcts and congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED January 9, 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/11/69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.						
24. FUNERAL DIRECTOR JOHN F. DENNY, INC.				ADDRESS 715 Light St.		25a. REC'D BY REGISTRAR DATA 13 1969		25b. REGISTRAR'S SIGNATURE K. C. Jones				

